



## **HealthPathWashington Advisory Team (HAT)**

### **Notes for July 24, 2012**

#### **Overview of Timeline**

- KPR started with a short update on the latest in discussions with CMS regarding health home funding. The draft Medicare shared savings formula CMS created does not share equally, so Washington and New York have proposed alternatives which CMS is reviewing. Resolving this formula could solve the 3<sup>rd</sup> year funding of health homes (after the 2703 90/10 match runs out).
- Clarifications and details were discussed regarding the timeline for Strategy 1, including the following:
  - An informal announcement regarding a non-binding letter of intent was sent on 7/23, but the formal notice is scheduled to go out 7/27 as noted on the timeline.
  - The letters of intent will be due back on 8/17, earlier than the 8/28 date shown on the timeline.
  - Because of the number of outstanding issues yet to be resolved with CMS, the 8/1 date shown on the timeline for signing an MOU is expected instead to be much later in August.
- The September 18<sup>th</sup> HAT meeting will focus on Strategy 2. KPR commented on the active engagement underway now with King, Snohomish, and Whatcom counties regarding this strategy.

#### **Letter of Intent Feedback**

- There is no information in the letter regarding the role or expectations of lead entities (other than performing administrative functions). I could not find anything on the HCA website that defines or explains this. How will organizations determine if they want to express interest in being a lead entity???
- The draft letter of intent indicated that it would include basic background documents (essential requirements, examples of lead entity administrative duties, proposed regional breakdowns).
- On question 2, when you reference an internal health home coordinator, do you mean care coordinator?
- In questions 2 & 3 you ask respondents to indicate proposed service areas. I assume from Tuesday's discussion that this means geographic area. Also, the draft letter asked about areas of expertise. This seems like really important information for the state to gather. Why is it omitted?
- Why was the submission deadline set at August 17th? I thought at the Tuesday HAT meeting the end of August was indicated.

#### **Miscellaneous Feedback**

- Several HAT members commented on the lack of information related to financing or proposed payment models that would support health home implementation and participation. It is critical that this is clearly communicated as part of the Request for Letters of Intent and the subsequent application materials.
- In Tuesday's discussion there was reference to professional qualification standards for Care Coordinator positions needing to be either RNs or MSWs. I did not see staff qualifications defined in the application or provider qualification and standards documents, but I did find this reference on page 23 of the May 8 Updated Second Revised Draft Health Home Proposal:

*Care Manager means a health care professional, licensed in the state of Washington, linked to a designated provider; or subcontractor responsible for providing care management services to enrollees. Care managers may be:*

- *A primary care provider delivering care management services in the course of conduct of care;*
- *A registered nurse, licensed practical nurse, or BSW or MSW prepared social worker employed by the health home;*
- *A registered nurse, licensed practical nurse, or BSW or MSW prepared social worker contracted by the health home;*
- *Staff employed by the primary care provider; and/or*
- *Individuals or groups subcontracted by the primary care provider/clinic or the health home.*
- Nothing in this definition precludes the health home or care manager from using allied health care staff, such as community health workers, peer counselors or other non-clinical staff to facilitate the work of the care manager.
- Since the expectation is to locate care managers (care coordinators?) in community-based settings reflecting the range of expertise needed by high-risk, high-cost beneficiaries (many of whom have serious mental health or addiction disorders) this list of licensed healthcare professionals is much too limited and should be expanded to include other licensed mental health professionals (e.g. marriage and family therapist, mental health counselor, psychologist).
- Definitions found in HH appendix to the design plan need to be included in the HH qualifications document.
  - *Definitions for Care Coordination, Care Management, and Case Management should be agreed upon and distinctly separate from each other.*
  - *“Provider” is problematic as it is being used inconsistently and/or too broadly. It is used in so many contexts that the documents are unclear as to their intent.*
  - *Introduce “strategy 1” and “strategy 2” if they are going to be used in the documents.*
- Need to be much clearer about the network adequacy standards required for a qualified HH network.
  - *Do we really intend that “ALL” provider have to be in a network?*
  - *Does a network have to include a hospital?*
  - *If a provider is not the lead entity and not delivering care coordination activities defined by ACA to receive any of the PMPM, why would they want or need to be part of the HH network?*
  - *Financing is not adequately discussed in the draft documents.*
- Much discussion revolved around clarifying the care coordination activities Health Options MCO’s are required to do under their new contracts and how that relates to the HH application process.
- Concerns were expressed about a workforce shortage possibly making it difficult to roll out qualified networks in such a short timeframe.
- Beneficiaries are concerned about having to tell their story to yet another person. Also, there was discussion about why a beneficiary would want to enroll in a HH. There are significant concerns about HIPAA and 42CFR requirements.
- Need to be clear about the requirement for cultural competency and what that will mean with regard to qualifying as a HH network.
- A suggestion was made that we consider tailoring health homes to various sub-groups of the population.

- A request was made to have demographic data available with the application.
- There was discussion about using only PHQ9 and the fact it doesn't cover SMI.
- The draft announcement regarding the letter of intent was discussed and much feedback was received.

### **Comments from the W4A members:**

- We believe that the Health Home requirements should be more prescriptive about what is required of the health homes in the way of long term care qualifications- the entity performing health homes for long term care consumers should be required to have CTI, Chronic Care Management, evidenced based programs in Aging & Disability Resource Centers (ADRC's), Family Caregiver Support Programs, as well as Chronic Disease Self-Management.
- We would like the HCA to be clearer about how they plan on evaluating (what measures will be used) the Health Homes; how they plan on evaluating and monitoring the effectiveness of Health Homes.
- We would strongly recommend that any incentive payments to HO MCO's include some performance success (not just cost savings) with Health Homes. An evaluation of the level of consumer engagement in proportion to the % of the incidence of 1.5 PRISM score by each MCO would be important in considering the effectiveness of a plan in supporting this higher cost, more vulnerable consumer population.
- We are very interested in the HCA/DSHS's consideration of the concerns that were raised in Sen. Rockefeller's letter to Secretary Sebelius (dated July 10, 2012). We share many of the core concerns and supports described in his letter, and would like to see Washington's Duals proposal and implementation efforts more focused on the benefits to consumers and approach development, not the anticipated savings as the primary goal to this effort. We strongly request that you share the Rockefeller letter with HAT members for their consideration and edification, in their role as advisors to HCA and DSHS.
- We feel more clarification on how payments will work in both the MCO and fee for service structures will work.

## **Questions**

### **W4As:**

- As I understand it, qualified health homes will be a part of both managed care (Healthy Options & Strategy 2) and Strategy 1. Is that correct?
- An "essential requirement" is to "include local community agencies..." What does include mean? Are all HHs required to contract or, at least establish an MOU, with the local AAA, RSN, etc.?
- Please clarify how the HHs will work? For non-Managed Care Organization health homes, what is the role of medical providers if they are not doing health home services directly?
- How will the payment mechanisms work? Under managed care will the payment be built into the PMPM rate? Will the plans receive payment regardless of services delivered? If not, how will payment be adjusted when beneficiaries decline service?
- If the health home is not managed by a MCO, will there be funding for start up costs? How and how much does the health home lead get paid? How will the state determine rates for providing HH services? The state talks about this being a fee-for-service model with a payment of \$150-\$180 per

month. No mention is made of payment for lead health home services. This payment level of \$150-\$180 is inadequate.

- There is a large percentage of the target population that is non-white and that speaks a language other than English. There needs to be clearer requirements for providing culturally and linguistically appropriate services.
- How will monitoring and evaluation of health homes work? Who will be monitoring all the component providers in the health homes? What are the evaluation measures? How will this effort be funded?
- Please clarify the difference between care coordination and intensive care management?
- Is it expected that each health home will develop and use its own health assessment tool or will there be a uniform health assessment tool? Is the state planning to review and approve the health assessment tools?
- It is stated that HCA and ADSA will be limiting the number of qualified Health Homes. What is the projected ratio of HHs to eligible population? How will the state determine which homes are chosen?
- On the timeline, there is nothing that talks about community outreach/education about health homes to eligibles. Shouldn't consumers be informed/educated/encouraged to participate?
- The LOI asks for "area of expertise". Aren't the HHs to include all areas – medical, behavioral, LTSS, etc.?
- In the application instructions page 2, it lists ten bases' for qualifying health homes. Please elaborate on what these mean.
- In the application instructions page 2, it states: "If the decision is made to implement on a geographical basis, this application will be reissued." What does this mean?
- In the application, Section B, #1, does "funded" mean paid for being part of the network and delivering HH services?
- What does "essential requirement" mean? What does it mean if an item is not identified as an essential requirement?
- In Section C, #8, what is the definition of "direct care worker"?
- In the Qualifications and Standards it states that the lead entity must have an NPI on file. Do AAAs qualify for an NPI?
- We would like to see it more clearly stated that interventions, education and informational materials be delivered in a language and culturally appropriate manner.
- The quality measures identified do not appear to include any performance measures for long term services and supports.
- These comments and questions were provided by the Aging & Long Term Care of Eastern Washington:
- After review of these documents, it does not look like being a primary health home applicant would be possible as an AAA, given the requirements. However, there is plenty of opportunity to partner and become part of a health home network. We would be well positioned to provide care coordination services (which seems to be one of the key components of the health home), especial for aging, disabled, and long term care populations. Our experience in chronic care management, care transitions, chronic disease self management, and connecting people with social services and supports is well suited to becoming an entity that provides care coordination.
- The required inclusion of a physician in the network requirement for the lead is unclear- what is the role of this physician?

- What is the plan for sustainability for Health Homes post the 8 quarters of Duals project?
- Case load note: AARP supports a tiered case load approach - with a specific lower ratio for the highest need clients. A rate of 50:1 is too high for highest need clients. We do not object to flexibility in who fills the role of caseworker (nurse, social worker, other) but we do object to the following language which deems even the 50:1 case load meaningless. "The caseload may be adjusted when community health workers, peer counselors or other non-clinical staff is used to facilitate the work of the assigned care coordinator."

#### **AARP:**

- Who decides who my health home network is?
- Will there be multiple networks in the same community?
- Who chooses my care coordinator? Will I have more than one coordinator?
- What if some of my providers are not in the HH network I am assigned to / choose?
- What incentive will my providers have to cooperate / communicate with the care coordinator?
- How many people will my care coordinator be responsible for supporting?

#### **WSMA:**

- What does a provider want for a reimbursement rate? May need to know this.
- Is proposed service is defined by geography or population type or both?
- How much will Doctors are reimbursed via their plan? Will it be the commercial rate?
- What does Network mean and is it OIC driven?
- Will enrollees be able to remain with their providers if the application is successful?

**NOTE: Please see accompanying documents for other feedback from HAT members**

#### **Next Meeting**

**September 18, 2012 1:00-4:00**

Location to be determined

A request was made to alternate meeting locations between Olympia and SeaTac/Seattle